Nos. 95-1858, 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,
Petitioners,

—v.—

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

STATE OF WASHINGTON, *et al.*,
Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURTS
OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL STUDENT ASSOCIATION AND A COALITION OF DISTINGUISHED MEDICAL PROFESSIONALS IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

The American Medical Student Association ("AMSA") and an ad hoc coalition of distinguished medical professionals respectfully submit this brief as *amici curiae* in support of Respondents. We file this brief with the consent of all parties.[1]

Founded in 1950, AMSA is an independent, non-profit organization representing nearly 30,000 physicians-in-training from medical schools across the country. AMSA, thus, represents the future of medicine in the United States.

The individual *amici*[2] are licensed medical professionals and educators with both clinical and academic expertise in the end-of-life issues confronting terminally ill patients. Some of us have written papers and articles on the clinical and bioethical aspects of end-of-life medical decisions; others have participated in the writing of guidelines and model statutes for the regulation of physician-assisted suicide. As a result of our experience, we are among the growing number of medical professionals who believe that, in certain limited and carefully-regulated circumstances, physician-assisted suicide should be a lawful option available to competent, terminally ill patients.[3]

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1. Copies of letters of consent are being filed with the Court at the same time as the filing of this brief.

2. See Appendix A for a fuller description of each of the individual medical professional *amici*.

3. *See, e.g.*, David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 New Eng. J. Med. 663, 666 (1996) ("Surveys of physicians demonstrate . . . majority support" for physician-assisted suicide.) ("Orentlicher, *Legalization*") (citations omitted); Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 New Eng. J. Med. 303, 306-07 (1996) (56% of Michigan physicians support legalization of physician-assisted suicide); Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1807 (1996) ("Emanuel, *Oncology Patients*") (45.5% of oncologists agree with physician-assisted suicide for patients in unremitting pain); Jonathan S. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians In Washington State*, 331 New Eng. J. Med. 89, 89 (1994)

We recognize that, for most patients, palliative care options exist and a physician can adequately ease a patient's suffering even when there is no cure for the patient's underlying condition. For this reason, we strongly support hospice and other comprehensive palliative care initiatives as the standard of care for the dying. When appropriate palliative care is adequate to relieve the patient's pain and suffering, we do not believe that physician-assisted suicide is an advisable option.

However, we also recognize that even the highest quality palliative care will not always adequately ease a patient's suffering. In such exceptional circumstances, mentally competent terminally ill patients should have the option of a safe, legal and state-regulated means of hastening death with the assistance of a physician.

SUMMARY OF ARGUMENT

Terminally ill patients who are competent and make a voluntary choice to hasten their death with the assistance of their physician should have the same right to control the time and manner of death as patients who refuse life-sustaining treatment. There is no clinical basis for distinguishing these two classes of patients based on purported categorical differences in either (*i*) the intent of the patient or the physician or (*ii*) the extent to which the active intervention of the physician affects the time and manner of the patient's death. Furthermore, criminal prohibition of assisted suicide compels many terminally ill patients to surrender their right to refuse unwanted and degrading medical treatment in order to relieve otherwise untreatable pain.

Petitioners' interests in protecting the ethical integrity of the medical profession and in limiting physician-assisted suicide to

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(54% of Washington doctors believe physician-assisted suicide should be legal in some situations).

competent, terminally ill patients who voluntarily choose to hasten their deaths also fail to support their general prohibition of the practice. Preventing physicians from assisting such patients is inconsistent with important principles of medical ethics because it may force doctors to abandon their patients, and to ignore their requests for information, assistance, and comfort, at a time when the patient is most in need because he or she is confronting both severe suffering and imminent death. Nor is it necessary to force competent patients to endure a prolonged, painful, and pointless process of dying in order to ensure that the practice of physician-assisted suicide is appropriately regulated. Detailed regulatory schemes have already been promulgated which involve the same types of medical judgments and legal protections that have been successfully used in other, long-established end-of-life decisions.

ARGUMENT

I. THE CLINICAL REALITIES OF TERMINALLY ILL PATIENTS DO NOT JUSTIFY THE LEGAL DISTINCTIONS URGED BY PETITIONERS.

Petitioners contend that it is constitutionally permissible for them to distinguish between the withdrawal or refusal of life support and physician-assisted suicide. Their justifications for such a distinction, however, simply ignore the clinical realities of terminally ill patients. Furthermore, in many instances, the artificial distinctions Petitioners seek to draw merely compel patients who are not on life support to surrender their right to refuse dehumanizing medical treatment in order to escape prolonged and intolerable suffering.

A. Medical Realities Do Not Support A Bright-Line Legal Distinction Between Refusal Of Life Support And Assisted Suicide.

The patients who brought these cases sought the same general right that this Court recognized in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990): to exercise the deeply personal choice to hasten the end of their lives as the only alternative to a painful and degrading process of dying. In denying this right to patients who seek the aid of their doctors in hastening their death, Petitioners rely on three purported categorical distinctions between such patients and those who refuse life-sustaining measures:

- whether the physician or the patient intend the patient's death or merely know that it is a foreseeable consequence of the physician's efforts to relieve suffering;
- whether the physician acts to hasten death or merely fails to take actions to prevent or delay death; and
- whether the time and manner of the patient's death is caused by medical intervention or is the "natural" result of an underlying illness.

These purportedly dispositive differences in intent, action, and causation, however, simply do not withstand scrutiny in light of the medical and clinical realities of terminally ill patients and their treatment. *See generally* Orentlicher, *Legalization* at 663 (explaining why categorical distinction between refusal of treatment and assisted suicide is no longer appropriate in light of changes in medical treatment of terminally ill patients).

1. Terminally Ill Patients And The Physicians Who Aid Them In Dying Intend To Give The Patient Control Of The Process Of Dying.

Petitioners contend that the intent of patients and physicians who participate in physician-assisted suicide is necessarily different from that of the patient and physician who refuse, withhold, or withdraw life-sustaining measures. In the case of physician-assisted suicide, the specific intent purportedly must be the death of the patient, *see Vacco* Pet'r Br. at 15-16; *Glucksberg* Pet'r Br. at 44, while where life-sustaining treatment is being refused, death is merely an unintended, albeit often inevitable, consequence of a desire to relieve the patient's suffering and indignity, *see Vacco* at 13-14. There is simply no basis, however, for presumptively ascribing such different intentions and purposes to patients and physicians in these two circumstances.

Such a simplistic and arbitrary account of the intentions of those who participate in physician-assisted suicide trivializes the inherently complex and multiple motivations involved in any end-of-life decision. *See* Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993) ("Quill, *Ambiguity*"). Thus, in requesting and prescribing a potentially lethal dosage of medication, the immediate goal of both patient and physician may be nothing more than to give the patient "a greater sense of control" over the process of dying and both may hope that the patient is never forced to take this final step in order to relieve their suffering. N.Y. Task Force On Life and Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 83 (1994) ("N.Y. Task Force Report"); *see also* Quill, *Ambiguity*; Timothy E. Quill, *Doctor, I Want to Die*, 7 JAMA 870, 872 (1993).

Indeed, in many cases, patients who have been prescribed

a lethal dosage never take the medication.[4] Rather, the medication serves its intended purpose by reassuring the patient that their terminal condition need not lead to dependency or indignity. *See, e.g.*, Susan D. Block, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2045 (1994) ("Block, *Patient Requests*") ("[A]cceptance of the patient's wish for hastened death . . . may paradoxically allow the patient enough control and confidence in his or her ability to manage the future so that the option of suicide does not have to be exercised."). For some patients, this sense that they retain control of their lives provides sufficient comfort to make their final days bearable. *E.g.*, Kingsley Decl. ¶¶ 11-12 (*Vacco* J.A. 99, 101-02); Grossman Decl. ¶¶ 15 (*Vacco* J.A. 84, 87); *see also* N.Y. Task Force Report at 92 ("The most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, un[a]esthetic, absurd, and existentially unacceptable condition.").

Even where the patient chooses to hasten her death, her ultimate goal is no different from that Petitioners ascribe to those who reject life sustaining treatment: to avoid a prolonged and dehumanizing process of dying. No less than those on life support, such patients seek to hasten death "because the quality of life during the time remaining . . . ha[s] been terribly diminished" and their life "has been physically destroyed and its quality, dignity and purpose gone." *See Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986) (describing patient's reasons for withdrawal of life support). Regardless of the means by which death is hastened, the intent and purpose of both categories of terminally ill patients are essentially the same.

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4. *See, e.g.*, Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) ("Back, *Physician-Assisted Suicide in Washington*"); Andrew Solomon, *A Death of One's Own*, New Yorker, 54, 58 (May 22, 1995) ("Solomon, *Death of One's Own*").

2. A Physician Who Withdraws Life Support Actively Causes The Patient's Death.

Equally meritless is Petitioners' attempt to distinguish assisted suicide from withdrawal of life support by arguing that, in the latter case, the physician takes no affirmative action that causes the patient's death. *See Vacco* Pet'r Br. at 17; *Glucksberg* Pet'r Br. at 30. This contention simply ignores the clinical reality of life-sustaining technology. For example, to disconnect a respirator, a physician or nurse must take each of the following steps:

1. turn off the respirator;
2. disconnect the machine from the tube that goes to the patient's lungs;
3. remove the tube from the patient's lungs;
4. administer morphine or barbiturates to ease the patient's sense of suffocation; and
5. monitor medication levels to ensure that symptoms of severe air hunger do not arise.

See Quill Supplemental Decl. ¶ 5 (*Vacco* J.A. 116-117) ("Quill Supp. Dec.").[5]

Furthermore, it is clear that when a patient is subject to on-going life-sustaining treatment, the withdrawal of that treatment will be a cause of the patient's death. For example, when a physician stops a respirator, death results because breathing stopped, but the cause of death is also the physician's act in halting the respirator. *See McKay v. Bergstedt*, 801 P.2d 617, 634 (Nev.

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5. Furthermore, when a patient refuses or requests withdrawal of life support, the physician may dispense drugs that ease the patient's suffering, but also hasten death. For example, when a doctor stops a patient's food and hydration, the ensuing bodily reaction requires the physician to treat these symptoms with sedatives that may hasten the patient's death. Quill Supp. Dec. ¶ 6 (*Vacco* J.A. 117-18).

1990) (Springer, J., dissenting). Similarly, when a physician halts food and hydration, death occurs because the patient is unable to eat or drink, but the physician is causally responsible for the death as a result of issuing the order to stop providing food and hydration. *See Brophy v. New Eng. Sinai Hosp. Inc.*, 497 N.E.2d 626, 631 (Mass. 1986) (Nolan, J. dissenting) (explaining that removal of feeding tube leads to death by dehydration and starvation). There can be no question that if a physician performed either of these actions without the patient's consent, she would be legally responsible for causing the patient's death just as surely as if she had shot her patient. *See* Orentlicher, *Legalization* at 663.

3. The Medical Environment In Which Terminally Ill Patients Typically Spend Their Final Days Necessarily Affects The Time And Manner Of Their Death.

Petitioners finally argue that refusal or withdrawal of life-sustaining measures and physician-assisted suicide are materially different because, in one case, the time and manner of death are the result of "natural" processes, while, in the other, they are affected by the action of physicians and other medical professionals. *See Vacco* Pet'r Br. at 17-18; *Glucksberg* Pet'r Br. at 12, 30, 38. This distinction also ignores the clinical reality of terminally ill patients.

It is a fundamental fact of contemporary medicine that death rarely occurs "naturally" and apart from significant medical intervention. Indeed, in 1992 nearly 80% of all deaths in this country occurred in hospitals. *See* Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Cal. L. Rev. 857, 858 (1992). In such a setting, both the time and manner of a patient's death are necessarily often the result of a series of conscious decisions and affirmative actions by the patient and her physicians.

In particular, the extensive medical treatment received by

most terminally ill patients will often have collateral consequences that affect both the timing and the manner of the patient's ultimate death in a way that makes it meaningless to describe death as occurring "naturally." *See, e.g.*, Froom Decl. ¶ 11 (*Vacco* J.A. 125, 126) ("With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt.").[6] For example, a cancer patient's chemotherapy may temporarily treat the illness, but it also may damage vital organs in the process and thereby affect when and how the patient may die. *See Clinical Oncology*, 789-813 (Martin D. Abeloff et al. eds 1995) (describing pulmonary and cardiac complications resulting from cancer therapy). Because the precise circumstances of death for most terminally ill patients will be determined in part by the effect of such medical interventions, the death of such patients cannot fairly be described as "natural."

B. Terminally Ill Patients Should Not Be Forced To Choose Between Enduring Severe Pain And Surrendering Their Constitutional Right To Avoid Unwanted And Dehumanizing Medical Treatment.

Although Petitioners and their *amici* suggest that adequate palliative care options are virtually always available for terminally

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6. The affidavits of the patients who brought the *Vacco* action graphically illustrate some of the effects of such treatments on terminally ill patients. *See, e.g.*, Barth Decl. ¶¶ 3-4, 9-10 (*Vacco* J.A. 96, 97-98) (describing adverse side effects of treatments for disease); Doe Decl. ¶ 10 (*Vacco* J.A. 106, 107) (describing scarring inside throat and neck from surgery and radioactive iodine treatment; burning and swelling in neck and nausea from radiation therapy; pain, nausea, and vomiting from tube feeding); Kingsley Decl. ¶ 8 (*Vacco* J.A. 101) (describing "cramping," "gas with bloating" and "total loss of appetite" from medication to prevent infection; administration of medication through Hickman tube connected to chest artery prohibited showering and made simple routine functions burdensome).

ill patients, *see, e.g., Glucksberg* Pet'r Br. at 18; American Medical Association ("AMA") *Vacco* Br. at 6-7, they ignore the cruel and dehumanizing nature of the "care" that may be required and the extent to which it may compel the patient to surrender his or her right to refuse unwanted and degrading medical treatment. In some instances, palliative care for terminally ill patients also impairs those patients' most basic bodily functions.[7] "Adequate" palliative care may also require extended periods of sedation to the point of permanent or temporary unconsciousness. *See* AMA *Vacco* Br. at 6 ("For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or *weeks of life* to prevent the patient from experiencing severe pain.") (emphasis added).[8] Indeed in some cases, patients may be sedated to the point where they require life support and then are "allowed to die" by withholding the necessary life-sustaining treatment.[9] This last practice

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7. *See, e.g.* Kingsley Decl., ¶ 8 (*Vacco* J.A. 101); Grossman Decl. ¶¶ 13-14 (*Vacco* J.A. 86-87).

8. *See also* Robert E. Enck, *The Medical Care of Terminally Ill Patients* 166-172 (1994) (summarizing recent studies on degree and frequency of sedation of terminally ill patients); Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Med. 1785, 1786 (1996) ("some [terminally ill] patients may require profound sedation"); Nathan I. Cherny et al., *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. of Palliative Care 31, 36 (1994) (adequate palliative care for the terminally ill may require sedation involving permanent or temporary "total loss of interactional function"; attempts to adjust dosages of sedatives "to reestablish lucidity after an agreed interval or for pre-planned family interactions" risk "possibility that lucidity may not be promptly restored or that death may ensue as doses are again escalated"). In addition, there can be no certainty that a patient who has been sedated to unconsciousness will, in fact, cease to experience pain. *See* Michael P. McQuillen, *Can People who are Unconscious or in the "Vegetative State" Perceive Pain?*, 6 Issues in L. & Med. 373 (1991).

9. *See* Robert J. Hall, *Final Act: Sorting Out the Ethics of Physician-Assisted Suicide*, 54 Humanist 10 (Nov./Dec. 1994) ("Hall, *Final Act*") ("The most recent answer to such problems, which may well become standard practice, is to sedate these patients into complete unconsciousness and to withhold nutrition and hydration until they die."); Timothy E. Quill et al.,

illustrates the utter artificiality of the line Petitioners seek to draw.

Terminally ill patients may refuse such palliative care based on their right to refuse unwanted medical treatment. *E.g., Cruzan*, 497 U.S. at 279; *Vacco* Pet'r Br. at 10. But the price of exercising this right is to remain conscious and to suffer both intolerable pain and an awareness of all of the indignities resulting from the ravages of the illness and its treatment. Doe Decl. ¶ 9 (*Vacco* J.A. 107) ("[I]t is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state."); Klagsbrun Decl. ¶ 16 (*Vacco* J.A. 71) ("Pain management at the end stage of cancer often requires the patient to choose between enduring unrelenting pain or sacrificing an alert mental state to the high dose of drugs adequate to alleviate pain."). In short, for some terminally ill patients, the choice Petitioners offer between palliative care or extreme pain and suffering is both cruel and meaningless.

II. PHYSICIAN-ASSISTED SUICIDE IS FULLY CONSISTENT WITH PETITIONERS' INTEREST IN PROTECTING THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION.

Petitioners' contention that they can require terminally ill patients to endure unnecessary and intolerable suffering in order to vindicate their interest in maintaining the integrity and ethical standards of the medical profession, *see Vacco* Pet'r Br. at 14-15, 31-32, is equally misplaced. As even those who support Petitioners' position, such as the AMA, acknowledge, established principles of medical ethics fully support a physician providing

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Physician-Assisted Death: A Comparison of Terminal Sedation, Assisted Suicide, and Voluntary Active Euthanasia, (manuscript at 8, on file with author) ("the suffering patient is put into an iatrogenic coma, usually using barbiturates or benzodiazepines, and then dies of dehydration, starvation, or some other intervening complication, as all life-sustaining interventions are withheld").

medication that will hasten a patient's death where the patient has voluntarily chosen this outcome as the only means of relieving severe suffering. Petitioners and the AMA argue, however, that the same conduct becomes unethical where a physician frankly acknowledges, or otherwise reveals, that her aim is to assist the patient in controlling the time and manner of their death. This distinction, however, makes no sense as a matter of professional ethics or public policy. Indeed, the criminal prohibition of physician-assisted suicide prevents doctors from fulfilling important ethical obligations to dying patients and encourages furtive practices that are akin to voluntary euthanasia and have a greater potential for abuse.

A. The Prohibition Of Physician-Assisted Suicide Is Inconsistent With The Medical Profession's Obligation To Respect Patient Autonomy And To Comfort Rather Than Abandon The Dying.

Petitioners' criminal prohibition of physician-assisted suicide conflicts with the medical profession's well-established ethical obligations to respect patient autonomy and to continue to attend to and comfort their patients, even when they may have an incurable illness. Indeed, it forces doctors to choose between violating the law and abandoning patients at a time when they are most in need and have expressed a desire to hasten their death as the only way of avoiding intolerable and untreatable suffering.

A traditional role of the physician, and a central goal of medicine, is to help people die with meaning, comfort and dignity. *See* AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, Opinion 2.20, at 40 (1996) ("*AMA Code*") ("Physicians have an obligation to relieve pain and suffering and to promote the

dignity and autonomy of dying patients in their care.").[10] In addition, as the AMA Council on Ethical and Judicial Affairs acknowledges in its opinion on physician-assisted suicide, medical ethics mandate that "[p]atients should not be abandoned once it is determined that cure is impossible." *AMA Code*, Opinion 2.211, at 56.[11] Indeed, "[t]o allow a [terminally ill] patient to experience unbearable pain or suffering is unethical medical practice." Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 847 (1989).

The principle of patient autonomy is equally central to medical ethics and to defining the physician's role in end-of-life decisions. As the AMA Council on Ethical and Judicial Affairs stated in its opinion on withholding or withdrawing life-sustaining medical treatment, "[t]he social commitment of the physician is to sustain life *and* relieve suffering. *Where the performance of one duty conflicts with the other, the preferences of the patient should prevail.*" *AMA Code*, Opinion 2.20, at 39 (emphasis added); *see also id.* at 40 ("Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying

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10. *See also* Medical Society of the State of New York, *Principles of Professional Conduct*, ch. 1, § 1 (1995-96) ("The prime object of the medical profession is to render competent medical service with compassion and respect for human dignity."); Eric J. Cassel, *The Nature of Suffering and the Goals of Medicine*, 306 New Eng. J. Med. 639, 639 (1982) ("The obligation of physicians to relieve human suffering stretches back into antiquity."); Hall, *Final Act*; John R. Peteet, *Treating Patients Who Request Assisted Suicide -- A Closer Look at the Physician's Role*, 3 Archives Fam. Med. 723, 726 (1994).

11. *See also AMA Code*, Opinion 8.11, at 123 ("Once having undertaken a case, the physician should not neglect the patient."); Howard Brody, *Assisted Death -- A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) ("[W]alking away, denying that medicine can do anything to help in the patients's plight, is an immoral abrogation of medical power, especially in cases in which the prior exercise of the medical craft has extended the patient's life and resulted in the complications that have brought the patient to the present state of suffering."); Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 Annals Internal Med. 368, 368 (1995).

patients in their care.").[12] Each patient must be allowed to make life-and-death decisions within the broader context of her own beliefs concerning the purpose and value of her existence. After all, "health and life extension are ultimately of value in the service of the broader overall well-being of the patient. They are of value in so far as they facilitate the patient's pursuit of his or her overall plan of life; the aims, goals and values important to the particular patient." Dan W. Brock, *Death and Dying*, in *Medical Ethics* 329, 334 (Robert M. Veatch ed. 1989). Thus, medical professionals should respect a patient's decision to hasten her death when the patient's remaining life offers nothing more than an intolerable and undignified process of dying. *See AMA Code*, Opinion 2.211, at 56 ("It is understandable, though tragic, that some patients in extreme duress -- such as those suffering from a terminal, painful, debilitating illness -- may come to decide that death is preferable to life.").

B. A State's Interest In Preventing Doctors From Intentionally Harming Patients Does Not Justify A General Prohibition Of Physician-Assisted Suicide.

Petitioners and their supporting *amici* contend that their interest in maintaining the integrity of the medical profession justifies a general prohibition against intentionally hastening the death of a patient even where precisely the same conduct would be lawful if done solely to relieve the patient's suffering. This distinction between instances where a doctor intentionally assists a patient in ending her life and so-called "double effect" cases in

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12. AMA Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992) ("[The AMA recognizes that] a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.").

which death is foreseeable, or even certain, but purportedly not intended is not supported by either medical ethics, legitimate policy considerations, or common sense.[13]

Petitioners argue that the principle that doctors should not intentionally harm their patients trumps all the other ethical considerations that support physician-assisted suicide.[14] This takes an unreasonably narrow view of what may constitute harm for a patient suffering irremediable and severe pain and confronting an imminent and unavoidable death. For such a patient, death may constitute not harm but the only available relief; the true harm may lie in being compelled either to continue unnecessary suffering or

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13. The AMA formally explained its position on the "double effect" doctrine in an opinion by its Council on Ethical and Judicial Affair which stated that "pain medications may be [ethically and legally] administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of . . . causing death through respiratory depression." AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 95 (1994); *see also AMA Code*, Opinion 2.20, at 40.

14. Although the AMA relies on the Hippocratic Oath for this proposition, *see* AMA *Vacco* Br. at 5, it is clear that the Oath does not represent the best or final word on modern medical ethics and controversies. Even at its inception, the Oath was not accepted by all ancient physicians. *See Roe v. Wade*, 410 U.S. 113, 131-32 (1973); *Encyclopedia of Bioethics*, Appendix at 2632 (Warren T. Reich ed., rev. ed. 1995). In fact, the strict provisions of the Oath forbid many medical procedures which are widely accepted today as ethical or legal, including abortion, "double effect" pain medication, and even surgery in any form. *See Encyclopedia of Bioethics*, Appendix at 2632 ("I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. . . . I will not use the knife, . . . but will withdraw in favor of such men as are engaged in this work.") (quoting Hippocratic Oath). For this reason, it has often been "retranslated" or modified. *See, e.g.*, Noah Adams, *Doctor Examines Evolution of Hippocratic Oath*, National Public Radio transcript #2199-4, April 30, 1996 (noting that at Johns Hopkins Medical School, the oath used at graduation ceremonies has been altered to "I will give no drug or perform no operation without a justifiable purpose."). Thus, the Hippocratic Oath should have no greater weight here than it did in determining whether women have a constitutional right to an abortion. *See Roe*, 410 U.S. at 131-32.

to end one's life in a lonely and violent manner.[15]

Furthermore, by sanctioning the practice of directly administering medications that will foreseeably cause a patient's death, the "double effect" doctrine allows physicians to engage in practices that are far closer to voluntary, or even involuntary, active euthanasia than physician-assisted suicide. *See* Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 N. Eng. J. of Med. 1678 (1992) (describing practice of administering barbiturates to relieve pain of terminally ill patients with unavoidable side effect of hastening death).

Nor is there any basis for believing that an open and legal practice of physician-assisted suicide would undermine patients' trust in their doctors because patients will come to view their doctors as killers. *See* AMA *Vacco* Br. at 21. First, it is difficult to see how more openness in the doctor-patient relationship will lead to less trust. To the contrary, imposing criminal liability only where there is evidence of the physician's intent to hasten death has

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15. Examples of such suicides are numerous: patients have jumped from bridges, withheld their own insulin to die of insulin shock, shot themselves in the head, suffocated themselves with plastic bags, and taken overdoses of prescription or over-the-counter drugs. *See, e.g., Compassion in Dying v. Washington*, 79 F.3d 790, 834-35 & n. 135 (9th Cir.), *cert. granted*, 117 S. Ct. 39 (1996); *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996); Solomon, *Death of One's Own*, at 57. Moreover, a patient who seeks to commit unassisted suicide (or suicide assisted by a layperson) is most likely unaware of what drugs or dosage they must use. Physical inability or miscalculation can lead to an even more drawn-out, painful and undignified death. *See, e.g.*, Russel D. Ogden, *Euthanasia: Assisted Suicide & AIDS* (1994) (approximately half of the layperson-assisted suicides were unsuccessful and increased the patient's suffering, rather than mitigating it); *Compassion in Dying*, 79 F.3d at 836 n.135; *Quill*, 80 F.3d at 721 ("Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts."). In addition, the negative effects of a violent unassisted suicide on the patient's family members extends the tragedy far beyond the individual patient. *See, e.g., Compassion in Dying*, 79 F.3d at 835 ("My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.") (quoting Brief of Amicus Curiae of Ten Surviving Family Members). When a family member assists the suicide, the negative effects can be irremediable. *See id.* at 835-36 & n. 135-36.

a chilling effect on the patient's ability to communicate freely with and receive critical information from his doctor. Second, this concern "is based upon the simplistic assumption that trust implies only that physicians will do no harm. The fact is that many patients now want to trust that their physicians will stay with them and will not abandon them when the only way out of their suffering is to help them to die as they choose." Hall, *Final Act*, at 14.[16]

III. REGULATION OF PHYSICIAN-ASSISTED SUICIDE IS FEASIBLE AND WOULD BETTER SERVE PETITIONERS' INTEREST IN PREVENTING POTENTIAL ABUSE THAN THE CURRENT SECRET PRACTICE .

Although Petitioners and many of their supporting *amici* concede the compelling nature of the suffering of individual terminally ill patients such as those who brought these actions, *see, e.g., Vacco* Pet'r Br. at 19; *Glucksberg* Pet'r Br. at 16; U.S. *Glucksberg* Br. at 21, they nevertheless contend that such patients must be forced to endure intolerable suffering because there is no way to effectively regulate the practice of physician-assisted suicide to ensure that it is limited to such patients and only exercised voluntarily, *see Vacco* Pet'r Br. at 29-31; *Glucksberg* Pet'r Br. at 44-47.[17]

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16. Petitioners' further attempt to justify their criminal ban by contending that, once freed of the prohibition from intentional harm, medical providers might resort to encouraging physician-assisted suicide as a means of reducing health care costs, *see Vacco* Pet'r Br. at 29, ignores the far greater economic incentives providers have for reducing the enormous costs of life-sustaining treatment for the terminally ill. This argument can not, therefore, support the line Petitioners seek to draw.

17. The State of Washington, as well as *amici* States, also argue that holding that a categorical criminal prohibition of physician-assisted suicide puts an undue burden on the exercise of such rights would somehow limit each State's "broad range of discretion" to develop appropriate regulations in this

Medical decisions concerning physician-assisted suicide are, however, no more subject to error or abuse than other end-of-life decisions, such as refusal of life-sustaining treatment, which have been effectively regulated by States for more than two decades. Indeed, the risks involved in such decisions do not essentially differ from the numerous decisions that patients must make concerning procedures that involve a significant risk of mortality.[18]

Both statistical and anecdotal evidence indicate that the practice of physician-assisted suicide, although illegal in virtually all states, is prevalent throughout the United States.[19] Legal

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area. *Glucksberg* Pet'r Br. at 16; *see also id.* at 47-49; *Amici* States Br. at 27-30. To the contrary, however, it would plainly allow States to develop a variety of appropriate substantive and procedural regulatory standards, such as those discussed below.

18. In support of their contention that physician-assisted suicide can not be effectively regulated, Petitioner Vacco and various amici, *see, e.g., Vacco* Pet'r Br. at 24 n.14; AMA *Glucksberg* Br. at 11-12, also point to the 1991 Remmelink Study, which studied the effects of the de facto legalization of both physician-assisted suicide and voluntary euthanasia in the Netherlands. However, a review of that study and its 1996 successor reveals that such reliance is misplaced. Rather, as the authors of the most recent report conclude, their data simply "do not support the idea that physicians in the Netherlands are moving down a slippery slope" towards "less careful end-of-life decision making and . . . the gradual social acceptance of euthanasia performed for morally unacceptable reasons." P.J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699, 1705 (1996). To the contrary, the reports show that "Dutch physicians continue to practice physician-assisted dying only reluctantly and under compelling circumstances." Marcia Angell, *Euthanasia in the Netherlands -- Good News or Bad?*, 335 New Eng. J. Med. 1676, 1677 (1996).

19. *See, e.g.*, Back, *Physician-Assisted Suicide in Washington*, at 919 (12% of Washington physicians received requests for assistance in suicide and in nearly 25% of those requests, prescribed a potentially lethal drug); David J. Doukas et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055, 1058 (1995) (38% of the 250 practicing oncologists in Michigan had been asked to participate in physician-assisted suicide and 18% had done so); Emanuel, *Oncology Patients* at 1808 ("More than 50% of oncologists had received requests for euthanasia or

recognition and regulation of physician-assisted suicide would only foster the Petitioners' interest in ensuring that the practice is limited to appropriate circumstances and is done in a manner that minimizes any potential for abuse.[20]

A. State Regulation Of End-of-Life Decisions Is Already Well-Established.

Legalized physician-assisted suicide would not be the first instance of state regulation of important end-of-life decisions. To the contrary, virtually every jurisdiction in the United States has regulations governing both living wills and decisions concerning the withdrawal or withholding of life-sustaining treatment in the absence of advance patient directives. These regulations require medical professionals to make judgments similar to these involved

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physician-assisted suicide [and] 13.5% said they had participated in physician-assisted suicide"); Terri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 Archives Internal Med. 722, 725-26 (1993) (Rhode Island survey of 393 physicians concluding 18.9% had been asked to prescribe a lethal amount of sleeping pills and 13.3% did so at least once); Melinda A. Lee et al., *Legalizing Assisted Suicide -- Views of Physicians in Oregon*, 334 N. Eng. J. Med. 310, 313 (1996) (21% of Oregon physicians had been asked in the last year to provide physician-assisted suicide and 7% had done so); *see also* David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844 (1989). These studies most likely underestimate the extent of the practice in the United States because they depend upon self-reporting of an illegal act that can easily be kept secret and because other health care professionals, including nurses, also assist in suicides. *See* David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1374 (1996) (study of critical care nurses across the country concluding that 17% were asked to assist in a suicide or perform euthanasia and 16% had done so at least once).

20. Furthermore, studies of the attitudes of terminally ill patients suggest that it is the patients who are assumed to be most vulnerable, such as those with limited cognitive ability or lower income or education, who look with least favor on the option of physician-assisted suicide. *See, e.g.*, H.G. Koenig et al., *Attitudes of Elderly Patients and their Families toward Physician-Assisted Suicide*, 156 Archives of Internal Medicine 2240, 2247 (1996).

in physician-assisted suicide and demonstrate how procedural safeguards can ensure that patients make end-of-life decisions competently and voluntarily.

For example, health professionals and lawyers have implemented state laws concerning living wills for more than twenty years.[21] Patient declarations regarding the withdrawal of life support are currently regulated in forty-seven states, the District of Columbia and the Virgin Islands.[22] Regulation in most states

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21. For example, the California Natural Death Act (Cal. Health and Safety Code §§ 7185-7194.5) was enacted in 1976. In addition, since 1991, the federal Patient Self-Determination Act, 42 U.S.C. §§ 1395cc, 1396a (1994), has required health care providers to have written institutional policies regarding living wills and to document whether or not a patient has executed such an instrument. Such institutional policies often mandate the involvement of the hospital ethics committee to oversee the process and the decisions taken with regard to the execution and implementation of living wills.

22. Ala. Code §§ 22-8A-1 to -10; Alaska Stat. §§ 18.12.010 to 18.12.100; Ariz. Rev. Stat. Ann. §§ 36-3201to 36-3262; Ark. Code Ann. §§ 20-17-201 to-218; Cal. Health & Safety Code §§ 7185-7194.5; Colo. Rev. Stat. §§ 15-18-101 to -113; Conn. Gen. Stat. §§ 19a-570 to -580; Del. Code Ann. tit. 16, §§ 2501-2509; D.C. Code Ann. §§ 6-2421 to -2430; Fla. Stat Ann. §§ 765.101-765.401; Ga. Code Ann. §§ 31-32-1 to -12; Haw. Rev. Stat. §§ 327D-1 to 327D-27; Idaho Code §§ 39-4501 to -4509; 755 Ill. Comp. Stat. Ann. §§ 35/1 to 35/10; Ind. Code Ann. §§ 16-36-4-1 to -21; Iowa Code §§ 144A.1 to .12; Kan. Stat. Ann. §§ 65-28,101 to 65-28,109; Ky. Rev. Stat. Ann. §§ 311.621 to 311.644; La. Rev. Stat. Ann. §§ 40:1299.58.1 to 40:1299.58.10; Me. Rev. Stat. Ann., tit. 18-A, §§ 5-801 to -817; Md. Code Ann.., Health-Gen. I §§ 5-601 to 5-618; Minn. Stat. §§ 145B.01 to 145B.17; Miss. Code Ann. §§ 41-41-101 to -121; Mo. Ann. Stat. §§ 459.010 to 459.055; Mont. Code Ann. §§ 50-9-101 to -111, -201 to -206; Neb. Rev. Stat. Ann. §§ 20-401 to -416 and §§ 30-3401 to -3452; Nev. Rev. Stat. §§ 449.535 to 449.690; N.H. Rev. Stat. Ann. §§ 137-H:1 to H:16; N.J. Stat. Ann. § 26:2H-53 to 2H-78; N.M. Stat. Ann. §§ 24-7-1 to -11; N.C. Gen. Stat. §§ 90-320 to -322; N. D. Cent. Code §§ 23-06.4-01 to -14; Ohio Rev. Code Ann. §§ 1337.11 to 1337.17, 2133.01 to 2133.15; Okla. Stat. Ann. tit. 63, §§ 3101.01 to 3101.16; Or. Rev. Stat. §§ 127.505 to 127.660; 20 Pa. Cons. Stat. Ann. §§ 5401-5416; R.I. Gen. Laws §§ 23-4.10-1 to 23-4.10-12, 23-4.11-1 to 23-4.11-14; S.C. Code Ann. §§ 44-77-10 to -160; S.D. Codified Laws §§ 34-12D-1 to 34-12D-22; Tenn. Code Ann. §§ 32-11-101 to -112; Tex. Health & Safety Code Ann. §§ 672.001 to 672.021; Utah Code Ann. §§ 75-2-1101 to -1119; Vt. Stat. Ann. tit. 18, §§ 5251 to 5262; V.I. Code Ann. tit. 19, § 192; Va. Code Ann. §§ 54.1-2981 to -2993; Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.920; W. Va. Code §§ 16-30-1 to -13; Wis. Stat. Ann. §§ 154.01 to

follows a similar pattern. Declarants are restricted to individuals over the age of eighteen who are of "sound mind"[23] or "competent."[24] Further, all declarations must be signed and witnessed,[25] and the patient must have a "terminal," "incurable" or "irreversible" condition, or be "permanently unconscious," before the instructions may be followed.[26] Several other common procedural safeguards include: restrictions on who may act as a witness (*e.g.*, those who stand to benefit financially from the patient's death or those who are employed by the relevant medical facility are barred);[27] a mandatory second opinion as to the patient's

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154.15; Wyo. Stat. Ann. §§ 35-22-101 to -108. The three states that do not regulate living wills have all enacted "health care proxy statutes" which allow designated agents to make health care decisions, including the withdrawal of life support, whenever the patient is no longer able to make treatment decisions. *See* Mass. Gen. Laws Ann. ch. 201D, §§ 1-17; Mich. Comp. Laws §§ 700.496; N.Y. Pub. Health Law §§ 2980 to 2994.

23. *See, e.g.*, Cal. Health and Safety Code § 7186.5(a); Ohio Rev. Code § 1337.12(A)(1); N.H. Rev. Stat. Ann. § 137-H:3; 20 Pa. Cons. Stat. Ann. § 54.04(a).

24. *See, e.g.*, Colo. Rev. Stat. § 15-18-104; Fla. Stat. Ann. §§ 765.102(1), 765.302(1); Mo. Ann. Stat., § 459.015; Tex. Health & Safety Code § 672.003(a); Va. Code Ann. § 54.1-2983.

25. *See, e.g.*, Cal. Health & Safety Code § 7186.5(a); D.C. Code Ann. § 6-2422; Fla. Stat. Ann. § 765.302(1); Tex. Health & Safety Code § 672.003(b); Va. Code Ann. § 54.1-2983.

26. *See, e.g.*, Ark. Code Ann., § 20-17-202; Cal. Health & Safety Code §§ 7185.5(d), 7186.5(b); Conn. Gen. Stat. § 19a-575a; Fla. Stat. § 765.303; 20 Pa. Cons. Stat. Ann. § 5405(2); Va. Code Ann. § 54.1-2983; Wa. Rev. Code §§ 70.122.010, 70.122.030(1).

27. *See, e.g.*, Cal. Health & Safety Code § 7285.5(a); D.C. Code Ann., § 6-2422 (4); Ohio Rev. Code Ann., § 1337.12 (B); Tex. Health & Safety Code § 672.003(c); Wa. Rev. Code § 70.122.030(1).

condition;[28] and record-keeping requirements.[29]

B. Comprehensive Regulations For Physician-Assisted Suicide Have Already Been Promulgated.

Various comprehensive schemes for regulating physician-assisted suicide have already been developed. These include (*i*) the Oregon Death with Dignity Act, (*ii*) the Harvard model statute, so-called because several of its authors are affiliated with Harvard University, and (*iii*) the guidelines promulgated by the Bay Area Network of Ethics Committee ("BANEC").[30] These regulatory schemes draw on the previous extensive experience of health professionals and lawyers in making and regulating other end-of-life decisions. They include the following procedural safeguards:

- Those requesting physician-assisted suicide must be adults suffering from a terminal or intractable and unbearable illness. *See* Harvard Model § 3(a)(2); BANEC Gd. V.A(1); Or. Rev. Stat. § 127.805.

- The request must be voluntary (*i.e.*, free of undue

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28. *See, e.g.*, Cal. Health & Safety Code §7186.5(b); Colo. Rev. Stat. § 15-18-107; Fla. Code Ann. § 765.303(1); D.C. Code § 6-2422 (c); Kan. Stat. Ann. § 65-28, 103(c); Ohio Rev. Code § 1337.11(y); 20 Pa. Cons. Stat. Ann. § 5408.

29. *See, e.g.*, Cal. Health & Safety Code § 7189; Kan. Stat. Ann. § 65-28, 103 (b); Mo. Rev. Stat. §459.015(2); 20 Pa. Cons. Stat. Ann. § 5404 (D); Tex. Health & Safety Code § 672.003(e); Wa. Rev. Code § 70.122.030(1).

30. *See* Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800 to 127.995; Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) ("Harvard Model") (attached hereto as Appendix B); Bay Area Network of Ethics Committees (BANEC), *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill* (Sept. 1996) ("BANEC Gd.") (attached hereto as Appendix C).

influence), informed, and repeated on at least two occasions. *See* Harvard Model § 3(a)(3)(C), (D); BANEC Gd. V.A(4), F; Or. Rev. Stat. §§ 127.805, 127.830, 127.840.

- A second opinion in writing must be sought to confirm the diagnosis of the patient. *See* Harvard Model § 5(a); BANEC Gd. V.B; Or. Rev. Stat. § 127.820.

- A second opinion as to the mental state of the patient must be submitted in writing. Harvard Model § 5(b); BANEC Gd. V.B; Or. Rev. Stat. § 127.820. In particular, the second physician must confirm that the patient's judgment has not been distorted by clinical depression or other mental illness. *See* Harvard Model § 5(b); BANEC Gd. B; Or. Rev. Stat. § 127.825.[31]

- Patients must be informed of, and offered, all reasonable palliative care options. *See* Harvard Model § 4(a); BANEC Gd. V.C; Or. Rev. Stat. § 127.815.

- Patients must be informed of their diagnosis, prognosis, and the various benefits and burdens of the available medical options, including physician-assisted suicide. *See* Harvard Model § 5(d); BANEC Gd. V.E; Or. Rev. Stat. § 127.815.

- Patients must be counseled to consult with their family. *See* Harvard Model § 4(c); BANEC Gd. V.D; Or. Rev. Stat.

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31. Under the Oregon statute, whenever, in the opinion of the attending or consulting physician, a patient may be suffering from a mental disorder or depression causing impaired judgment, the patient must be referred for counseling and the person performing the counseling must determine that the patient is not suffering from such problems. *See* Or. Rev. Stat. § 127.825.

§ 127.835.

- Patients must be informed that they may consult a third party, *e.g.*, a social worker, or a hospital ethics committee. *See* Harvard Model § 4(b); BANEC Gd. V.D.

- The patient must execute a signed, witnessed request for physician-assisted suicide.[32] The witnesses must be individuals who do not stand to benefit from the patient's death and who are not affiliated with the relevant health care facility. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810. In certain cases (*e.g.*, if the patient is in a skilled nursing facility), the presence of a state-appointed witness is required. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810(4).

- The patient must be informed that he or she may revoke the request. *See* BANEC Gd. V.G; Or. Rev. Stat. § 127.845.

- All documentation, including the declaration, the opinion of the attending physician, and the second opinions, must be included in the patient's medical record. *See* Harvard Model §§ 4(d)(3), 5(c), 6 (does not include the patient's request); BANEC Gd. V.A-H; Or. Rev. Stat. § 127.855.

- Attending physicians must prepare detailed reports which are either filed with or made available to State health

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32. Model written forms can be found in BANEC Guidelines -- Attached Form #2 and Or. Rev. Stat. § 127.897. The Harvard Model has no equivalent provision and allows an oral request. However, the physician's discussion with the patient regarding the patient's diagnosis and prognosis and the benefits and burdens of the treatment options (including physician-assisted suicide) must be witnessed and either recorded on video or audio tape or transcribed and signed by the patient. Harvard Model § 4(d); *see also* BANEC Gd. V. E; Or. Rev. Stat. § 127.810.

officials.[33]

C. Regulation Of Physician-Assisted Suicide Is Just As Feasible As Regulation Of Other End-Of-Life Decisions.

Each of the key concepts involved in assessing the appropriateness of physician-assisted suicide has been used for years in making and regulating other end-of-life decisions by patients and their doctors. There is no basis for believing that such regulations could not similarly ensure that physician-assisted suicide is appropriately limited to terminally ill patients who have made their decisions competently, voluntarily and with the best available information concerning their medical condition and options.

1. Terminal Illness

Determinations of terminal illness have been used as a basis for end-of-life decisions for more than two decades and form part of the regulatory schemes of virtually all States, including Petitioners New York and Washington.[34] Thus, both physicians and hospital ethics committees have extensive experience in determining when a patient is terminally ill.

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33. For example, under the Harvard model statute, the attending physician must file a detailed report with the state Health Commissioner. *See* Harvard Model § 6. The Commissioner may review the reports and medical records in order to prepare an annual report on the operation and success of the statute. *See id.* § 9(d). The BANEC Guidelines propose the creation of a state registry which would be able to request, for review, the full medical records of all patients, including details of the hastened death. The registry would track complete demographic information and issue an annual report detailing its findings. *See* BANEC Gd. V.K.

34. *See, e.g.*, N.Y. Pub. Health Law § 2961(23); Wash. Rev. Code Ann. § 70.122.020(9).

Although the risk of misdiagnosis can never be entirely eliminated, a number of studies suggest that erroneous prognoses of the terminally ill tend to be overly optimistic. *See, e.g.*, Ronald S. Schonwetter et al., *Estimation of Survival Time in Terminal Cancer Patients: An Impedance to Hospice Admissions*, 6 Hospice J. 65 (1990); Lorna E. Forster et al., *Predicting Life Span For Applicants to Inpatient Hospice*, 148 Archives Internal Med. 2540, 2542 (1988). Moreover, even if an illness is misdiagnosed by a primary physician as "terminal," there are a number of subsequent safeguards and procedures which could reduce the risk of error before physician-assisted suicide would be permitted. For example, the Harvard model statute provides for a mandatory second opinion as to the severity of the patient's condition. Harvard Model § 5(a).

More importantly, legalization of physician-assisted suicide, in contrast to the current secret practice, would ensure that patients will make such decisions based on frank and full discussions with their doctors concerning their medical condition and options and that their doctors can freely consult with other medical professionals. Furthermore, because physician-assisted suicide will be limited to patients whose suffering is severe and untreatable, the risk of an overly pessimistic diagnosis must be weighed against the unendurable condition in which the patient might survive. In such circumstances, an overly optimistic prognosis may risk as severe harm to the patient as an overly pessimistic one. *Cf. Cruzan*, 497 U.S. at 320 (Brennan, J., dissenting) (an erroneous decision to keep alive a patient on life support is just as irrevocable as an erroneous decision to remove life support because the patient's "own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted").

2. Informed Consent

The requirement of informed consent is a concept familiar to all health care professionals as part of any decision to undergo medical treatment and is a well-established feature of the health law of both New York and Washington.[35] Because of the seriousness of the decision to elect physician-assisted suicide, additional safeguards can ensure that the patient has all of the medical information necessary to make her decision and that there is a sufficient record so that the adequacy of the information provided to the patient can be subject to review. For example, the Harvard model statute requires that the responsible physician shall:

> supply to and discuss with the patient all available medical information that is necessary to provide a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens.

Harvard Model § 4(d). This discussion must be witnessed by two individuals "at least one of whom . . . must not be affiliated with any person that is involved in the care of the patient, [or] . . . stand to benefit personally in any way from the patient's death." *Id.* § 4(d)(1). The medical discussion must be either recorded on video or audio tape or summarized in a document which the patient signs. *See id.* § 4(d)(3). The physician must inform the witnesses that

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35. *See* N.Y. Pub. Health Law § 2441 ("'Voluntary informed consent' means the legally effective knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion."); *Villanueva v. Harrington*, 906 P.2d 374, 376 (Wash. 1995).

they "may question the . . . physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed." *Id.* § 4(d)(2). In addition, the model statute mandates the involvement of at least three health care professionals at different points in the process (the primary physician, consulting physician and licensed psychiatrist, clinical psychologist or psychiatric social worker), all of whom will discuss the matter with the patient. Finally, the written opinion on the patient's competence must specifically address whether the patient's decision is "fully informed." *Id.* §§ 5(a), (b).

3. Voluntariness

Assessments of voluntariness are also a well-established aspect of existing schemes for regulating other end-of-life decisions. For example, most living will statutes include provisions intended to ensure that end-of-life decisions are made voluntarily, such as requirements that multiple witnesses be present at the time the living will is executed. *See supra.* Additional protections can ensure that individuals are not coerced into choosing physician-assisted suicide. For example, the Harvard model statute requires that the patient's request be made on separate occasions at least two weeks apart. Harvard Model § 3(a)(3)(D). In addition, a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient must make a written finding that the patient's judgment is "free of undue influence." *Id.* § 5(b).

4. Competence Or Capacity

Assessments of a patient's capacity to make a medical decision are also a common and well-established aspect of medical practice. Indeed, "[t]here appears . . . to be a developing consensus regarding the meaning of capacity in cases dealing with medical

decision making, including those concerning life-sustaining treatment. This consensus is toward accepting the meaning of capacity implied in the Restatement of Torts [§ 892A], namely the ability to appreciate the nature, extent, or probable consequences of the physician's conduct to which consent is given." 1 Alan Meisel, *The Right to Die* § 3.19, at 100 (2d ed. 1995).[36]

The Harvard model statute again suggests how states can adopt the general standards of competency to the special circumstances of terminally ill patients to ensure that decisions are not "the result of a distortion of the patient's judgment due to clinical depression or any other mental illness." Harvard Model § 3(a)(3)(A); *cf.* Martha Alys Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 Cal. L. Rev. 707 (1987) (proposing test for determining competency of patients who seek to hasten death). In order to ensure that the patient fully understands the nature of their decision, the Harvard model statute requires consultation with a licensed psychiatrist, clinical psychologist, or psychiatric social worker, who must provide a written opinion that the patient is not seeking physician-assisted suicide due to clinical depression or mental illness. Harvard Model § 5(b). Well-established criteria exist, such as prior mental illness, and the intensity and consistency of the symptoms, which allow psychiatrists to differentiate between clinical depression and mere feelings of sadness and grief. *See* Block, *Patient Requests*, at 2042.

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In short, all of the assessments that medical professionals would need to make to ensure that physician-assisted suicide is

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36. *See, e.g.*, N.Y. Pub. Health Law § 2980 (3) ("Capacity to make health care decisions' means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.").

limited to appropriate circumstances are currently being made by physicians in virtually all States -- including those of Petitioners themselves -- in connection with other, equally weighty end-of-life decisions. Numerous proposals have already been developed with extensive procedural protections to minimize the possibility of risk of error or abuse in aiding terminally ill, suffering patients to voluntarily hasten their own deaths. There is no justification, therefore, for a categorical criminal prohibition of the practice.

CONCLUSION

For the reasons stated above, *amici* urge this Court to affirm the decisions of the Courts of Appeals for the Second and Ninth Circuits.

December 10, 1996

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1. The individual medical professionals do not necessarily represent the views of those organizations with which they are affiliated.

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APPENDIX B

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

SECTION 1. STATEMENT OF PURPOSE

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for continuing oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

SECTION 2. DEFINITIONS

As used in this Act,

(a) "Commissioner" means the Commissioner of the Department.

(b) "Department" means the Department of Public Health [or similar state agency].

(c) "Health care facility" means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.

(d) "Intractable and unbearable illness" means a bodily

disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.

(e) "Medical means of suicide" means medical substances or devices that the responsible physician prescribes for or supplies to a patient for the purpose of enabling the patient to end his or her own life. "Providing medical means of suicide" includes providing a prescription therefor.

(f) "Patient's medical record" means (1) in the case of a patient who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

(g) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

(h) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient.

(i) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

SECTION 3. AUTHORIZATION TO PROVIDE ASSISTANCE

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a

patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

(1) the patient is eighteen years of age or older;

(2) the patient has a terminal illness or an intractable and unbearable illness; and

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request

(A) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

(B) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

(C) has been made free of undue influence by any person; and

(D) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this Act may, if the patient so requests, be present and assist the patient

at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

SECTION 4. DISCUSSION WITH PATIENT AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's cares sufficiently to cause the patient to reconsider his or her request for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits

and burdens, all in accordance with the following procedures:

(1) at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (A) is not affiliated with any person that is involved in the care of the patient, and (B) does not stand to benefit personally in any way from the patient's death;

(2) the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information pursuant to this paragraph (d), and discussed pursuant to this paragraph (d); and

(3) the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:

(A) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or

(B) a written summary of the discussion that the patient reads and signs and that the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

SECTION 5. PROFESSIONAL CONSULTATION AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

SECTION 6. RECORDING AND REPORTING BY THE RESPONSIBLE PHYSICIAN

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

SECTION 7. ACTIONS BY PERSONS OTHER THAN THE RESPONSIBLE PHYSICIAN

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

SECTION 8. RECORD KEEPING BY THE DEPARTMENT

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(b) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation of this Act. Such report shall include, at a minimum, the following information:

(1) the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical

practice, that the responsible physician advised the patient were practicably available;

(2) the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;

(3) the patient's vital statistics, including county of residence, age, sex, race, and marital status;

(4) the type of medical insurance and name of insurer of the patient, if any:

(5) the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and

(6) the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

SECTION 9. ENFORCEMENT AND REPORTING BY THE DEPARTMENT

(a) The Commissioner shall enforce the provisions of this Act

and shall report to the Attorney General and the appropriate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and may by regulation require the submission of such information to the Department.

SECTION 10. CONFIDENTIALITY OF RECORDS AND REPORTS

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

SECTION 11. PROVIDER'S FREEDOM OF CONSCIENCE

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

SECTION 12. PATIENT'S FREEDOM FROM DISCRIMINATION

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or

entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

SECTION 13. LIABILITY

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to an individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

SECTION 14. CRIMINAL PENALTIES

In addition to any other civil, criminal, or disciplinary liability that he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].

APPENDIX C

BAY AREA NETWORK OF ETHICS COMMITTEES

BANEC-GENERATED GUIDELINES FOR
COMPREHENSIVE CARE OF THE TERMINALLY ILL

(NOTE: These guidelines are intended for use regardless of the patients' residence -- home, hospital, hospice, clinic, or extended care facility -- as they approach death.)

I. The ultimate responsibility for the care of the patient, pertaining to end-of-life decisions and treatments, resides with the patient's physician.

II. The primary care physician is qualified to provide appropriate care, with or without consultation, for the great majority of patients who are dying.

III. The care of patients experiencing "difficult deaths," those undergoing (in their judgment) intolerable or prolonged suffering as they die, or patients who are making complex and irreversible decisions about end-of-life (including the decision to hasten death), may fall out of the range of skills of many primary care physicians.

Hospice programs have extremely effective teams which provide medical care had help patients with their decisions about end-of-life treatments. Certain physicians in the medical community are also recognized to have special expertise in palliative, end-of-life care. For those patients who face difficult deaths, or those who are making complex and irreversible decisions about terminal care (including a request for physician aid in hastening their death), THE BANEC GUIDELINES URGE REFERRAL TO A HOSPICE PROGRAM AND/OR CONSULTATION WITH A PHYSICIAN EXPERIENCED IN

PALLIATIVE CARE (including, but not limited to, pain control). Many patients, given appropriate and skilled palliative end-of-life care, will withdraw their requests for a hastened death.

IV. At times, in spite of skilled physical, psychological, spiritual and social care, an adult, mentally competent and terminally ill patient will desire a physician's aid in hastening death.

V. These guidelines urge that, before a physician aids a patient to hasten his or her death, the following occur (with specific documentation in the patient's hospital chart and/or outpatient medical records):

(NOTE: No physician, nurse, physician-assistant, pharmacist, or other health care worker is required to participate in the act of hastening a patient's death, nor in the patient's evaluation for such an act. However, these guidelines recommend that participation practitioners who exclude themselves from such participation respond to a patient's request for a hastened death by advising that patient of his or her right to obtain consultation from other practitioners, and/or facilitating the transfer of care should the patient so request.)

Chart documentation should include:

A) The primary care physician's ascertaining of:

1) The terminal diagnosis (a reasonable certainty of death within six months provided the disease runs its expected course, ascertained by review of the medical records and pertinent history and physical examination).

2) An assessment to confirm that, in the best judgement of the physician, the patient is mentally competent and not suffering from a depression that impairs decision making capability. (IT IS HIGHLY RECOMMENDED THAT PHYSICIANS NOT EXPERIENCED WITH SUCH AN EVALUATION SEEK APPROPRIATE AID, WITH THEIR PATIENT'S CONSENT, FROM OTHER PRACTITIONERS IN THE MEDICAL, PSYCHOLOGICAL, OR SOCIAL SERVICES COMMUNITY.)

3) That high-quality palliative care, by hospice and/or a physician recognized to have expertise in palliative care, has been made accessible to the patient.

4) That, to the best of the physician's knowledge, the patient's choice to hasten death has been freely made, independent of financial, family, health insurance, or other coercion.

B) A second opinion to confirm the four points noted above by the primary care physician. These guidelines strongly recommend that the second opinion be obtained from a physician recognized to have expertise in palliative end-of-life care.

C) Documentation of the patient's evaluation by a hospice program and/or physician with palliative care expertise (this can coincide with the second opinion noted above). Documentation should also be made of the palliative-care recommendations resulting from this evaluation, and the ways in which they have or have not been followed.

Alternately, documentation should be made that the patient declines an evaluation for improved palliative care. These guidelines recommend that these patients sign a form (see

attached) to indicate an understanding that they have waived a medical evaluation that could offer care with significant potential for improving their quality of life as they die.

D) The patient has been counseled that a decision to hasten death should, if at all possible, be discussed in detail with family members, loved ones, and others who are likely to be significantly affected by this decision.

The patient has also been counseled that the hospital and hospice medical ethics committees are valuable and willing to discuss his/her care, and the decision to hasten death, with the patient and/or family.

E) A witnessed consent form should be signed by the patient (see example attached), to include full disclosure of the illness, the procedure to aid the patient in hastening death and the associated risks, and a statement that other medical options exist (including hospice care) that might provide further comfort without hastening death.

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or

adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

F) A second witnessed signature by the patient must be obtained, no sooner than 48 hours after the first signature.

G) Before aiding the patient in hastening death, there should be chart documentation of verbal counseling that the patient has the right, at any time, to change his or her mind and to return to care that includes the involvement of a hospice team or another physician experienced in palliative care.

H) Chart documentation that the physical process of hastening death was initiated and completed by the patient: These guidelines emphasize that the physician may aid the patient in the process of hastening death (i.e. by provision of oral or injectable medication, or the starting and maintaining of intravenous access), but it should be the patient's own physical effort that initiates and completes the process.

(NOTE: In the BANEC discussions of this document, a significant minority felt that section H draws an artificial mechanical boundary between a "patient initiated" hastened death and a physician's act of administration of drugs once other guideline recommendations have been met. However, since the 9th Circuit Court addressed only physician assisted suicide, the final BANEC guidelines reflect this limitation and refer only to a "patient initiated and completed" process.)

I) These guidelines emphasize that, although it is the patient who undertakes the proximate action that leads to the hastened death, a physician or the physician's designee responsible for the care of the patient should remain immediately and continuously available to the patient and family until death has occurred.

J) The cause of death on the death certificate should be listed as the underlying disease.

K) Reporting: These guidelines urge that a system similar to that of the California Tumor Registry (including the confidentiality of information) be established to which all cases of physician aid in the hastening of a patient's death be reported. This registry would be able to request, for review, the full medical records of the patient, including details of the hastened death. The registry should track complete demographic information and issue an annual report detailing its findings. This report should be accessible to the public.

It is also recommended that existing hospital, hospice and community clinic peer-review organizations include cases of aid in hastening deaths in their mandate of review.

This document is a blueprint for potential policy, to be used as deemed appropriate by individuals or organizations. The Bay Area Network of Ethics Committees provides a forum for open, independent discussion of ethical issues in healthcare. Opinions and guidelines proffered via BANEC are not necessarily representative of or endorsed by any individual or organization participating in BANEC discussions, and are non-binding in all cases.

FORM #1: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

DOCUMENTATION OF OFFER OF CONSULTATION
AND SERVICES BY HOSPICE OR OTHER
PALLIATIVE CARE EXPERT

NAME:_____

My physician, _____, has recommended that I be evaluated by a hospice program and/or another physician, both of which have special expertise in controlling the emotional, spiritual and physical suffering that can be associated with dying. It is my understanding that hospice programs and such physicians can provide the optimal treatment for terminally ill patients such as myself, and that such treatment might include improved treatment for the pain associated with my illness, treatment and counseling for possible depression or other psychological or social issues, or other problems related to my condition. I further understand that while such treatments will not cure my condition or significantly extend my life, they do have the potential to improve my quality of life. It has been explained to me that a consultation with hospice is readily available to me, and that hospices can make arrangements that will not place additional financial burdens on myself or my family while they provide such services.

After due consideration of this information and offer of referrals, I hereby certify that:

- ☐ I decline the recommendation of a consultation with hospice personnel or physician; or
- ☐ I have accepted the referral and have consulted with (check one or more):

- ☐ Hospice representatives
- ☐ Another physician as referred to by my primary physician
- ☐ Other: _____

_____ _____
Signature of patient Date

_____ _____
Signature of witness Date

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients In a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

_____ _____
Signature of primary physician Date

_____ _____
Signature of translator (if applicable) Date

FORM 2: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

INFORMED CONSENT-- REQUEST FOR
PHYSICIAN ASSISTED DEATH

Patient's name: _____

I, the above-named patient, being of sound mind, have of my own free will and in consultation with my physician and others close to me, decided that it is my desire to end my life. I hereby certify that:

I am an adult resident of the State of California;

I believe, and my physicians agree, that I am mentally competent to make decisions regarding my life and death;

I have a confirmed terminal diagnosis with a reasonable prediction that, if the disease runs its expected course, I will die within six months of this date;

I am making this choice to hasten death of my own free will and have not been convinced or coerced to do so by any other persons or party, including any insurer or payor involved in the finances of my health care;

I have been offered full use of medical and hospice services and expertise for the improvement of my condition and quality of life, including management of my pain and discomfort; and have either availed myself of such consultations or have declined to do so;

I have also been offered consultation with an ethics committee of a hospice or hospitals and have or have not undertaken this consultation in accordance with my best judgement;

I have, in accordance with my best judgment, discussed (or chosen not to discuss) this final decision with any members of my family or others who will be affected by my death;

I have discussed the process to be utilized to hasten my death, its risks, and alternatives, and have chosen this method as my preferred means of ending my life;

I retain the right at any time to change my mind and withdraw my request to die. I understand that all other options for care, including hospice and other measures that are likely to make me more comfortable, continue to be available to me at all times.

First request: _____
Signature

Date:_____ Time:_____

Second request: _____
Signature

Date:_____ Time:_____
(Must be 48 hours from first request)

Signature of witnesses of patient's first signature: (NOTE: The selection of witness is in accordance with the regulations now established for the signing of a Durable Power of Attorney for Health Care Decisions).

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Signature of witness of patient's second signature:

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Name and signature(s) of translator (if applicable):_____
Date: _____ Time: _____

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses

who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

FORM 3: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

REPORT OF A PHYSICIAN-ASSISTED DEATH
(To be completed by the patient's primary physician)

(NOTE: All cases of assisted death should be reported to an appropriate organization. Until such time as an official reporting entity has been established, the BANEC guidelines recommend reporting to the local Health Department, hospital or hospice ethics committee, or an established peer review or quality assurance committee.)

This information will be held confidential and will be reviewed for compliance with recommended standards of practice only. It is hereby agreed that the patient's complete medical records may be requested by such a review committee, and I hereby agree to provide these records if so requested.

Patient name (or identifying code): _____
Patient's date of birth: _____ Age: _____ Sex: _____
Ethnicity: _____
Physician: _____
Patient's diagnosis: _____
Second physician who confirmed terminal diagnosis: _____
Date of death: _____
Location of death: (Institution/home/or?): _____
Physician's relation to patient (check one):

- ☐ I have been the patient's primary physician for ____ months/yrs.
- ☐ Patient was referred to me to deal with the illness/symptoms which led to the request for hastened death. Date of referral: __

☐ I believe patient was referred to me specifically regarding the hastening of death. Date of referral: _____

First witnessed request for a hastened death:
Date: _____ Time: _____

Second witnessed request for a hastened death:
Date: _____ Time: _____

Diagnosis and symptoms leading to patient's request: _____

Was patient referred for palliative care/hospice consultation:
☐ Yes ☐ No

Did the patient accept this consultation: ☐ Yes ☐ No
If Yes: Date of consultation: _____
By whom: _____
Outcome: _____

Please attach copies of signed forms:
1) Documentation of Offer of Consultation and Services by Hospice or Other Palliative Care Expert.
2) Informed Consent for Physician Assisted Death.
3) Physician Checklist in Assisted Death Cases.

Location of patient's medical records: _____

Mode of assisted dying utilized: _____

Other comments (use other side of form and additional pages as needed).

FORM #4: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

PHYSICIAN CHECKLIST IN ASSISTED DEATH CASES
(to be completed before the hastening of a patient

Patient's name: _____
Physician's name: _____

Prior to assisting in the death of a patient, please confirm the following:

☐ The patient is an adult resident of California.
☐ As the patient's physician, I am well aware of the patient's medical history, condition, diagnosis and prognosis.
☐ The patient's condition is terminal, with death otherwise expected to occur within six months of this date.
☐ A second physician has confirmed this terminal diagnosis.
☐ The patient is mentally competent and able to exercise rational thought processes in making decisions regarding their health care.
☐ High-quality palliative care, by hospice and/or physicians qualified to provide such care, has been offered to the patient, with full understanding that such care might result in an improved quality of life in the patient's remaining days.
☐ If such care has been refused by patient, such refusal has been documented by signed consent form.
☐ To the best of the physician's knowledge, the patient's choice to die has been freely made, independent of financial, family, health insurance, or other sources of coercion.
☐ The patient has been offered consultation with an ethics committee.

- ☐ The patient has been offered counseling by psychiatrist, therapist, social service worker, clergy or other.
- ☐ The patient has been counseled to discuss his/her decision with any family members, loved ones, or others who will be affected by this decision.
- ☐ The patient has made the required two signed, witnessed requests, at least 48 hours apart, for a hastened death.
- ☐ The patient has been offered appropriate means by ending his/her life, with full disclosure of the process, pros and cons of each, and has made an informed choice of which intervention will be utilized.
- ☐ At the time of the procedure, the patient is still competent, has made a third, final request, with witness(es) present, and has been advised that the procedure may be halted at any time upon the patient's request, with a return to optimal palliative care as an option.
- ☐ A healthcare professional (physician or nurse) with expertise in this area has been identified who will remain immediately and continuously available to assure that distressing symptoms are minimized via appropriate palliative means.

Following death, the usual confirmation and reporting requirements are in effect, with the addition of the reporting form for physician-assisted death.

NARRATIVE SECTION (OPTIONAL): PLEASE UTILIZE THE BACK OF THIS FORM AND/OR ADDITIONAL PAGES TO ADD ANY COMMENTS DEEMED APPROPRIATE REGARDING THIS PATIENT'S CASE.

_____ _____

Physician's signature Date